Attachment 2: Performance Indicators for the 2002-2003 Performance Agreement

REQUIREMENT	INTENT and AUTHORITY	MEASUREMENT	MONITORING and RESPONSIBLE PARTY	CONSEQUENCES FOR NON - PERFORMANCE
Fiscal Management 1: Maintain responsible accounting, reimbursement and financial management practices so as to provide continuous unrestricted fund balance of at least one month's operational costs and to assure consistent availability of services to clients within overall funding levels. For single counties that do not provide fund balances, county managers should provide sufficient financial backing for the program to assure consistent availability of services to clients within overall funding levels.	Assist in ensuring compliance with: a. G.S. 122C-112(a)(16), which addresses requirements related to financial management and fiscal accountability. b. G.S. 122C-124(a), "Area Authority Funding Suspended", which addresses budget deviations and significant changes in fund balance. c. G.S. 122C-125, "Area Authority financial failure; State assumption of financial controls", which addresses financial failure and the assumption of control by the State. d. G.S. 122C-144.1(b), "Budget Format and Reports", which addresses the Secretary's authority to require periodic reports of receipts and expenditures. e. 10 NCAC 14C .1018, "Area Authority Financial Failure Defined", which addresses expenditures, revenues, fund balance and failure to comply with reporting requirements.	a. Review and follow-up on financial issues identified in the Area Program's annual audit, including a special focus on the Crosscutting Single Audit Supplement. b. Review of 8% (one month's operating costs) fund balance information based on Fiscal Monitoring Report and annual Tentative Settlement Report.	a. Analysis of quarterly Fiscal Monitoring Reports, including expenditures, revenues, changes in cash balance, accounts payable and accounts receivable. b. Review of annual Area Program audit. c. Review of financial stability measures. **(See Attachments 3 and 3a)**	• Publish monitoring findings in periodic reports on performance. • Referral of nonperformance items to local, state or federal auditors. • Require corrective action plan for deficiencies with specified timeframes for completion of improvements. • Withholding of funds. • Assumption of control of the financial affairs of the Area Program. • Contract directly for services which are not being provided in a timely manner. • Removal of program segment from Performance Agreement in current or future years. • Consider performance in subsequent year planning.

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Fiscal Management 2: Submit all reports required by law, regulations or the DHHS by assigned due dates in acceptable quality and comply with all the performance indicators that are tracked in the reports. Such reports include the following:				
• Quarterly Fiscal Monitoring Reports	Measure compliance for Area Program financial stability per G.S. 122C-112, G.S. 122C-124, G.S. 122C-125, G.S. 122C-144.1 and 10 NCAC 14C .1018.	a. Assessment of functioning related to compliance with the financial stability checklist, "Source of Financial Stability Information and When Might an Area Program Receive a Follow-Up Letter", Revised by DMHDDSAS January 13, 2000. b. Data included on Fiscal Monitoring Report, including but not limited to, annualized expenditure rates which exceed 110%, annualized revenue rates which are less than 90%, and a decrease in cash balance of 25% or more. c. Submission of Fiscal Monitoring Reports on time, i.e., the 20th day of the month following the end of the quarter.	Review of Fiscal Monitoring Reports and Financial Stability Checklist standards. **(See Attachments 3 and 3a)**	• Publish monitoring findings in periodic reports on performance. • Correspondence to Area Authorities and county managers regarding fiscal deviations. • Require corrective action plan for deficiencies with specified timeframes for completion of improvements. • Withholding of funds. • Deemed to be in danger of imminent financial failure. • Assumption of control by the State. • Removal of program segment from Agreement in current and future years. • Consider performance in subsequent years.
• Cost-finding Report	Ensure compliance with G.S. 122C-143.2(a), G.S. 122C-144.1(b), Funding Systems Operating Manuals Volume IV: Fiscal Requirements, and Volume VI: Cost Finding Requirements for the purpose of being able to set accurate Area Program purchase rates, including	a. Submission of annual or special cost findings by required due date. Annual cost finding submission due by November 1, 2001. b. Submission of accurate and complete cost finding data.	Review of cost finding submission for accuracy and completeness by DMH/DD/SAS staff, DHHS Regional Accountant and DHHS Controller Central Office staff.	• Publish monitoring findings in periodic reports on performance. • Denial or delay of funds, including Medicaid.

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	Medicaid rates.			
• Revenue Adjustment Reports	Ensure compliance with G.S. 122C-144.1(b) and Funding Systems Operating Manual, Volume IV: Fiscal Requirements.	a. Review of monthly revenue adjustment reports to ensure submission. b. Review of monthly revenue adjustment reports and compare to prior revenue adjustment reports to identify unusual variances.	Submission and review of monthly revenue adjustment reports.	• Publish monitoring findings in periodic reports on performance. • Require corrective action plan for deficiencies with specified timeframes for completion of improvements. • Denial or delay in funds.
• Documentation of paybacks for non-compliance items identified during the Annual Medicaid Services Audit.	Ensure compliance with the Service Records Manual for Area Authorities and Contract Agencies (APSM 45-2) and Medicaid reimbursement requirements (DMH/DD/SAS Medicaid Manual 7/1/89 and Medicaid Service Guidelines July 1999)	Review of Area Program payback report and reconciliation with DMA **Note: An Instructional Memo, similar to the one mailed on January 12, 2001, will be sent to Area Programs thirty days prior to the audit process.**	Submission of paybacks/adjustments to DMA Controller's Office and to DMA Program Integrity.	• Disenrollment by DMA of Area Program as a Qualified Provider
• SAPTBG Compliance Report **NOTE: The Federal Government is expected to be issuing changes to SAPTBG which have not been released yet. Therefore, the SAS requirements that are part of the block grant may be changing during the term of the agreement.**	Ensure compliance with the Substance Abuse Prevention and Treatment Block Grant (SAPTBG).	Measurement of compliance will be based on criteria for: • receipt of the report **(See Attachment 4)** • timeliness of report submission • completeness of report submission • compliance with conditions for funding.	• Review by SAS of the semi-annual Reporting Form.	• Publish monitoring findings in periodic reports on performance. • Referral of nonperformance items to local, state or federal auditors. • Require corrective action plan for deficiencies with specified timeframes for completion of improvements. • Delay, withholding, or denial of funds, or assessment of a financial penalty commensurate with nature and scope of problem. • Contract directly for services which are not being provided in a timely manner. • Consider performance in subsequent year planning.

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REQUIREMENT	INTENT and AUTHORITY	MEASUREMENT	MONITORING and RESPONSIBLE PARTY	CONSEQUENCES FOR NON - PERFORMANCE
• Substance Abuse/Juvenile Justice Initiative Quarterly Report	Ensure compliance with conditions for funding of all Substance Abuse/Juvenile Justice Initiatives, including Youth Academies, Detention Centers, Multi-purpose Homes, and MAJORS Programs.	Measurement of compliance will be based on criteria for: • receipt of the report **(See Attachment 5)** • timeliness of report submission • completeness of report submission • compliance with conditions for funding.	• Review by SAS of the quarterly Reporting Form.	• Publish monitoring findings in periodic reports on performance. • Referral of nonperformance items to local, state or federal auditors. • Require corrective action plan for deficiencies with specified timeframes for completion of improvements. • Delay, withholding, or denial of funds, or assessment of a financial penalty commensurate with nature and scope of problem. • Contract directly for services which are not being provided in a timely manner. • Consider performance in subsequent year planning. • Consider performance in subsequent year planning.
• TANF Work First Initiative quarterly reports.	The intent of this requirement is: • to measure the effectiveness and compliance with Work First requirements to screen, assess and provide care coordination for Work First applicants and recipients (G.S. 108A-29.1 and G.S. 108A-25.2) • to measure compliance with Work First legislative requirements for random toxicology screening as a part of substance treatment (G.S. 108A-29.1); and • to measure compliance with TANF Block Grant Funding requirements	Measurement of compliance will be based on 5 criteria that have been selected for the Work/First Substance Abuse Initiative for SFY 00-01. The criteria are: • receipt of the report **(See Attachment 6)** • timeliness of report submission • completeness of report submission • compliance with toxicology plan, protocol and toxicology screening of clients • WF QSAPs performing required TANF approved activities to validate level of TANF funding	• Review by SAS of the quarterly WF/SA Initiative Reporting Form • Annual onsite review of up to 30% of Programs.	• Publish monitoring findings in periodic reports on performance. • Referral of nonperformance items to local, state or federal auditors. • Require corrective action plan for deficiencies with specified timeframes for completion of improvements. • Delay, withholding, or denial of funds, or assessment of a financial penalty commensurate with nature and scope of problem. • Contract directly for services which are not being provided in a timely manner. • Consider performance in

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				subsequent year planning.
• Volume of Service submissions for: (1) Regular UCR; (2) Comprehensive Treatment Services Program Funding (former Willie M./ARC) UCR ; (3) Volume of Service submissions for UCR-MR/MI (Formally TS).	Ensure compliance with G.S. 122C-144.1, Funding Systems Operating Manuals Volume VI: Reporting Requirements, Volume VII: Thomas S. Requirements, and Comprehensive Treatment Services Program Budget and Unit Cost Reimbursement Manual.	a. Review of Volume of Service (VOS) for timely submission. b. Review of Area Program annual audit reports for any identified VOS reporting issues. Submission of Fiscal Monitoring Reports on time, i.e., the 20th day of the month following the end of the quarter. Review of Volume of Service (VOS) for timely submission. Review of Area Program annual audit reports for any identified VOS reporting issues.	The appropriate Section will monitor via the following activities: a. Review of VOS reports; b. Follow-up on an identified VOS issues identified in the Area Program audit report.	• For Developmental Disabilities, Consider performance in subsequent year planning. • Denial or delay of funds. • Publish monitoring findings in periodic reports on performance. • Require corrective action plan for deficiencies with specified timeframes for completion of improvements. • For Developmental Disabilities, after two consecutive quarters of late monthly report submissions, a Plan of Correction, specifying steps to be taken and timeframes for completion of improvements will be required.
Fiscal Management 3: Effective December 1, 2002, the Area Program, or County Program, as applicable, shall pay all provider invoices within thirty (30) calendar days after approval of the invoice, in accordance with the following provisions:	Powers and Duties of the Secretary pursuant to G.S. 122C-112.1(a) (20): "The Secretary shall ensure maximum accountability by area authorities and county programs for rate setting methodologies, reimbursement procedures, billing procedures, provider contracting procedures, record keeping documentation, and other matters pertaining to financial management and fiscal accountability." **(See Attachment 16.)**	The standard that the Division shall use in measuring the compliance of the Area Program with the invoice processing periods imposed by this section shall be the following: Ninety-five percent (95%) of approved invoices (excluding invoices for services rendered by the Area Program) are paid within thirty (30) calendar days after the approval. **(See Attachment 16.)**	The Area Program will submit a completed Invoice Data Sheet (Attachment 4C) to the Revenue/Regulatory Coordination & Management Section of DMHwithin forty-five (45) calendar days of the conclusion of the previous quarter. Within thirty (30) calendar days after the CMT receives the Invoice Data Sheet, the CMT will review the Area Program's Invoice Data Sheet to determine whether all approved non-Area Program invoices submitted during the subject quarter were paid within thirty (30) calendar days after approval at least ninety-five (95%) of the time and will report the results to the Area Program.	The Division will publish quarterly reports reflecting the performance levels of Area Programs that do not meet the 95% performance standard. The Division and Area Program will develop a corrective action plan for the Area Program if the Area Program does not meet the 95% performance standard.

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Fiscal Management 4: Area Program must have a current, signed TPA with the IPRS Fiscal Agent.	Area Programs *will not* be reimbursed for claims submitted if Electronic Data Systems (EDS) does not have a current, signed TPA with the IPRS Fiscal Agent.	Receipt of a signed TPA document by EDS.	The DMH/DD/SAS Information Technology Section will monitor through communications with EDS.	• No reimbursement to the Area Program. • Published Report.

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REQUIREMENT	INTENT and AUTHORITY	MEASUREMENT	MONITORING and RESPONSIBLE PARTY	CONSEQUENCES FOR NON - PERFORMANCE
Accountability 1: Implement reasonable, or agreed upon, corrective actions and management improvements as required by the Secretary, the Division, or as committed to by the Area Program from audits, program reviews, or quality improvement processes. Such reviews shall include, but not be limited to, Medicaid documentation audits, local single audits, Federal program audits, State program reviews and accreditation visits and reports.	Track and report on the development, implementation, and completion of any and all corrective actions issued to Area Authorities.		Reports will come from the various Division Sections to the Program Accountability Section upon the issuance of a corrective action. Program Accountability will enter these notices of corrective action into the Accountability 1 Database. Following a section's issuing a notice of corrective action, the section will routinely provide the Program Accountability Section with a status report of the Area Program's progress in responding and implementing the corrective action.	• Publish monitoring findings in periodic reports on performance. • Referral of nonperformance item to local, state, or federal auditors or to accrediting authority • Assess a financial penalty commensurate with nature and scope of problem. • Removal of program segment from Agreement in current or future year. • Consider performance in subsequent year planning.
Accountability 2: Maintain accreditation by the Council on Accreditation (COA), unless waived by the Division..	To assure the Area Program is accredited to provide services as required by the rules in NCAC T10: 14V Section .0600; To enhance the credibility of the accrediting process and to improve Area Program & Division accountability with consumers, payers, advocacy groups, legislators & other stakeholders; To provide additional measures of comparability of services across the statewide community-based system; To encourage and demonstrate continuous quality improvement in the Area Program with a focus on consumer & community needs and outcomes; and	An Area Program will be considered in compliance with this requirement if the area program has been fully accredited by June 30, 2002, and if accreditation has not been revoked at any time during Fiscal Year 2001-2002.	Schedules & associated reporting requirements for initial accreditation, maintenance of accreditation and re-accreditation are developed in conjunction with COA, the Area Authorities, & the Division. The Advocacy, Client Rights and Quality Improvement Section (ACRQI) publishes the schedules and monitors compliance & reporting requirements. ACRQI receives regular status reports & other notice(s) of developments pertinent to Area Program COA accreditation status in accordance with a formal COA-Division agreement to share information.	• Publish monitoring findings in periodic reports on performance; • Require corrective action plan for deficiencies with specified timeframes for completion of improvements; or • Potential withholding or loss of funds to provide service upon denial or revocation of accreditation.

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	To strengthen Area Program & Division capability to effect and to demonstrate positive change in the lives of consumers and their families.			
Accountability 3: Submit timely and complete client data reports for all clients as specified in each of following categories: • Client Data Warehouse (CDW); • Client Outcome Initiative (COI); • MR/MI Person Centered Plans; • NC Treatment Outcomes and Program Performance System (TOPPS) Assessments. • Participate in the Developmental Disabilities' Core Indicators Project • Local Community Collaboratives will submit Comprehensive Treatment Services Program waiting list data; • Single Portal Database; and • Complete the NC SNAP.				
• Client Data Warehouse submissions **NOTE: The Client Data Warehouse (CDW) is the Division's source of information to monitor program, clinical and demographic information on the clients served. The data are also**	The CDW has replaced the former Statistical Reporting System. • From the CDW, the Division generates SAS and MH Block Grant Reports for the Federal Government (A significant payer for Area Program Services); • Reports for the Performance	Monthly submission of data will be monitored. Items to be measured include: 1) Was there a monthly submission by 15th of the month? 2) Was the monthly submission of admission records (record type 11) at a level comparable to	Data is collected at the Area Authorities and submitted to the CDW database through data files. These files must be sent in standard Electronic Data Interchange (EDI) format – a single file with multiple record types. Monthly data file submission should be	• Each month the Area Authorities will electronically receive two error files: 1. Error files containing all the records that were rejected due to errors in the data. 2. CTL (Count) file containing a report of number of records

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used to respond to Departmental, Legislative and Federal reporting requirements.	Budgeting System; and • Other required reports Area Authorities are required to submit client data into the Client Data Warehouse (CDW). There are 11 possible record types for transmission to the CDW. These are: • Header Record • Identifying Information • Demographics • Consumer Discharge • Details • Diagnosis Details • Special Population Details • Risk Factors Details • Substance Abuse Details • Substance Abuse Treatment (movement) Details • Trailer Record In addition, an annual Demographic update file should be sent by August 15th of each year.	previous years? 3) Was the annual Demographic update file received by August 15th ? 4. Were 90% of all required data fields complete ? (1 quarter. lag time) 5. Were 85% of all mandatory and required data fields something other than "unknown" ? (1 quarter lag time). 6. Did 90% of the clients served each qtr. have Primary and Principal diagnosis? (lag time from end of qtr. date to admission date which allows 60 days to look at this data and report on it). 7. Did 90% of clients served each quarter have Principal Disability on the Disability detail record? (60-day lag time). 8. Did 90% of SAS Principal and Primary diagnosis have SAS detail records (record 17 and 18) within 90-days of admission?	sent by the 15th of the month. Data that passes all edits will be available for immediate analysis by Division Staff. Records with fatal errors (Mandatory data elements blank or invalid) will be returned to the Area Program electronically and must be resubmitted electronically. Each record in the error file will contain the error transaction, in the same format as sent, and followed by the error message. There will be a total number of transaction records at the end. Quarterly reports will be issued to indicate which records contain Required data elements that are missing or incorrect.	submitted, accepted, and rejected. • By the 30th day following the close of the quarter a quarterly corrective action letter, detaining the missing/invalid information on file, will be submitted to the Area Authorities. • Quarterly corrective action letters will be sent for unacceptable submission of data in the following instances: 1. Data file not sent, 2. Data file not sent by the 15th of the month, and/or 3. Percentage thresholds not met for measurement items 4-8.
• Client Outcome Initiative (COI) There are three instruments: 1) MH/SAS COI 2) DD COI 3) EI COI **NOTE: All area program clients**	Area Authorities are to complete COI instruments. The COIs are the first division-wide steps to provide baseline information on the clients served by Area Authorities. The MH/SAS COI provides information such as: client functioning (via GAF and CAFAS scores), hospitalizations, substance use, progress through school	The Program Evaluation Branch and Data Operations will generate an expected number of COI's to be completed by the Area Program. The expected number of initial COIs will be determined as follows: • The number of valid initial COIs that match to the CDW should be equal to 20% of the active caseload, as listed in the CDW	The Program Evaluation Branch and Data Operations will use the Client Data Warehouse database to determine the expected number of COIs to be completed each month by the Area Programs. The Data Operations Branch will monitor this requirement.	• Publish monitoring findings in quarterly report. • Require corrective action plan for deficiencies with specified timeframes for completion of improvements. • Potential withholding or loss of funds.

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with case numbers ending in 3 or 6 are expected to have completed one of these COI instruments with the following exception: Substance abuse clients who have completed the TOPPS.	and/or employment training, and use of crisis services. The EI COI provides information on family functioning and the child's progress in several skill areas. The Developmental Disabilities COI provides information about client participation and progress toward maximum independence.	after subtracting the number of clients administered the TOPPS. All of the required fields on a submitted COI must be complete for a COI to be considered valid. Area Programs will be considered in compliance with this requirement if they submit 90% or more of the expected initial COIs and 90% or more of discharge and update COIs within required timeframes.		
(At Risk Children Assessment and Outcome Instrument (AOI) has been deleted.)		.		
• MR/MI Person Centered Plans	• Per the Special Provision, Section 11.22, maintain system for oversight to assure that services are necessary and cost effective.	Quarterly reporting. A weighted item rating scale will be used for reporting timeliness and completeness of reports: • 0 = "Unacceptable" (No, or insufficient, Supporting Documents/Reports); • 1 = "Inadequate" (Insufficient Reporting); and • 2 = "Adequate" (Supporting documents/reports present and complete)."	Developmental Disabilities Section reviews the submission of all plans & reports and generates reports on timeliness & completeness of data submission on a quarterly basis.	• Publish monitoring findings in periodic reports on performance. • After two consecutive quarters of ratings less than two or an over all score less than 90%, a corrective action plan with specified timeframes for completion of improvements is required. • Potential loss of funds for Area Programs where plans continue to be delayed and where plans of correction fail to have an impact on implementation.
• NC Treatment Outcomes and Program Performance System (TOPPS) Assessments	Ensure measurement of client outcomes and program performance for the following special programs/populations: 1) Perinatal/Maternal 2) TANF/Work First	Measurement of compliance will be based on criteria for: • receipt of the report **(See Attachment 7)** • timeliness of report submission	Review by Substance Abuse Services of submitted TOPPS assessments.	• Publish monitoring findings in periodic reports on performance. • Require corrective action plan for deficiencies with specified timeframes for completion of

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	3) MAJORS 4) Narcotic Treatment 5) Casaworks Residental	• completeness of report submission		improvements. • Delay, withholding, or denial of funds, or assessment of a financial penalty commensurate with nature and scope of problem. • Consider performance in subsequent year planning.
• DD clients will participate in the DD Core Indicators Project and not in the Division Consumer Satisfaction Survey. **NOTE: While this indicator is listed in the Performance Agreement, its implementation is contingent upon the availability of funding. Area Programs will be notified of the funding status for this indicator during the fiscal year. If funding *cannot* be secured, then DD consumers will participate in the Division's annual Consumer Satisfaction Survey. If funding *is* made available, then the following indicator components will be effective.**	There are two Area Authority activities: 1. Consumer Satisfaction Surveys/Interviews require that the Area Authorities complete a random sample of DD consumers, ages 18 and older who have been receiving services and supports for at least one year. The random sample will be done with instruction from DD Section. Each Area Authority will be given a specific number (to be determined by the Section) of consumers that must be drawn randomly from the sample. The Area Authorities will then be responsible to obtain consent for participation. Once an individual has given consent, the Area Authority must complete a 4-5 page survey for each individual that will provide the interviewer with some contact and background information. 2. Family Support Surveys require that the Area Authority submit a list of family addresses, randomly drawn from the same sample as above. The number of addresses to be submitted will be determined by the DD Section.	• Completion of Pre-survey and background information; • Receipt of Family Addresses on labels Ratings for Completeness/Timeliness • 0 = "Unacceptable" (No Supporting Documents/Reports submitted after the deadline.) • 1 = "Inadequate" (Insufficient Reporting); and • 2 = "Adequate" (Supporting documents/reports are present and complete; reports submitted on time.)	• Analyze data through Program Support to be included in a national report and to be provided to Area Authorities. • Information collected throughout the fiscal year. Analysis and report to occur after end of fiscal year. All activities of the project will require the coordination of efforts between the Area Authorities, DD Regional Coordinators, DD Section, and UNC to obtain the correct information. • 90% or higher rating. • 2nd quarter reporting of status.	• Published Report; • 2nd quarter reporting of ratings. • Plan of correction due third quarter of fiscal year for ratings below 90%, or scores below 2.

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• Local Community Collaboratives will submit Comprehensive Treatment Services Program waiting list data	The intent of this requirement is to assess unmet service delivery needs of children eligible for the Comprehensive Treatment Services Program.	Area Programs will submit waiting lists developed by the Local Community Collaborative. These lists will provide data on children who are eligible for the Comprehensive Treatment Services Program funding but who are waiting for services.	For Area Programs who have children waiting for services, waiting lists are to be submitted to the Data Support Branch of the Information Technology Section on a quarterly basis, by the 20th of the month following the last month of the reporting quarter (i.e., October 20th, January 20th, April 20th, and July 20th. Area Programs who do not have children waiting for services are to send e-mail confirmation to Julie Seibert (Julie.Seibert@ncmail.net) on a quarterly basis, by the 20th of the month following the last month of the reporting quarter (i.e., October 20th, January 20th, April 20th, and July 20th.	• Publish monitoring findings in periodic reports on performance. • Require corrective action if Area Program does not submit data by established deadlines.
• Maintain current, accurate computerized Single Portal database reflecting content specified by the DD Section.	Single Portal data base for entry/exit To assure data on disc captures needs for services/supports that person identifies.	Measurement of this requirement is based on the following achieved ratings of timeliness and completion of the Waiting List report: • 0 = “Unacceptable” (No updated Reports; report submitted on or after the 30th of the reporting month); • 1 = "Inadequate” (Incomplete Reports; data submitted after the 15th but before the 30th of the reporting month); and • 2 = “Adequate” (Reports updated and complete; reports submitted on or before the 15th). Reports on 12/31 data should be	• Submission of analyzed Area Program data to the DD Section by 1/15 and 7/15; and • Analysis of the Area Program waiting list report by the DD Section. **NOTE: Reporting on this requirement will occur at the conclusion third and first quarters of the new State Fiscal Year.**	• Publish monitoring findings in. • For ratings less than 2, a Plan of correction will be required, specifying timeframes and the steps that will be taken to improve performance. • Loss of funding

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		submitted by 1/15; and Reports on 6/30 data should be submitted by 7/15.		
• Complete the NC SNAP	To identify levels of need for all individuals for : • Identification of services & supports • Identifying complexity of service needs for fiscal projection.	1. Measured by analysis of the following: • The number of consumers on the DD Wait list who have had and not had the NC SNAP as of 7/1/02; • The number of consumers In-Services who have had and not had the NC SNAP, as of 7/1/02; and 2. By the following assigned ratings for timeliness and completeness of data: • 0 = "Unacceptable" (No updated Reports; report submitted on or after the 30th of the reporting month); • 1 = "Inadequate" (Incomplete Reports; data submitted after the 15th but before the 30th of the reporting month); and • 2 = "Adequate" (Reports updated and complete; reports submitted on or before the 15th).	• DD Section will verify NC-SNAP, Wait List, and In-Service data against Single Portal, CDW, and Medicaid Receipt data to determine statewide compliance. **NOTE: Area Programs must submit all NC SNAP data as of 7/1/02 by 7/15/02.**	• Publish monitoring findings in first quarter (FY 02) Division Performance Agreement report. • For ratings less than 2, a Plan of correction will be required, specifying timeframes and the steps that will be taken to improve performance. • Potential loss of funding.
Client Rights & Relations 1: Administer the Division Client Satisfaction Surveys to Mental Health and Substance Abuse clients**,** consistent with Division standards and submit data received	Area Authorities are required to participate in the once a year Consumer Satisfaction Survey. All active Mental Health and Substance Abuse clients during the survey week	A submission log will be maintained which will indicate the submission of forms by form type and the Date of receipt. Client Satisfaction Surveys are	Data is collected at the Area Authorities and submitted to the Division in scannable copy forms provided by the Division. A notification letter of the survey week and complete instructions for completing the survey will be sent to	• Publish monitoring findings in periodic reports on performance. • A corrective action letter will be sent to each Area Program that fails to send survey forms by the close of the third week after the

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according to Division guidelines.	who are being served by the Area Program either directly of through contract should be given the opportunity to complete the survey. There are six possible forms that may be completed: 1) Adult – English 2) Adult – Spanish 3) Child – English 4) Child – Spanish 5) Parent – English 6) Parent – Spanish	required for 10%, but not more than 1,000, of each Area Program's most recent Mental Health and Substance Abuse caseloads.	Area Authorities at least six weeks in advance of the survey week. Forms will be provided at least three weeks in advance of the survey week. One survey is planned a year (Fall). The Fall survey will be conducted between late October and early November. All data should be returned by receipt required mail within three weeks of the close of the survey. A de-identified data file will be returned to Area Authorities within one week of the completion of scanning for their own analysis. A statewide report will be disseminated to the Division and the Area Authorities. All data will be scanned within six weeks of the receipt of the survey.	survey period ends. • A corrective active letter will be sent to each Area Program that falls below a 90% response rate for the 10% of caseload criteria. This letter will be sent with the statewide report. • Corrective action letters will be sent in conjunction with each survey period.
Access 1: Provide access to services for eligible children in DSS Custody in an attempt to improve penetration rates from FY 02 to FY 03, subject to available funding.	Area Authorities are responsible for improving access to mental health services for children in DSS custody, as these children are at risk for emotional disturbance. Area Authorities are to maintain or increase penetration rates of children served. Individual Area Program SFY 00 data will be used to establish baseline data. This will be compared with SFY 01, SFY 02, and SFY 03 data.	This data will be represented as a penetration rate by the following equation: **A / B = Penetration Rate** Where: **A** = Number of children in DSS custody receiving MH services from Area Authorities. This number will be obtained from Medicaid paid claims	Data is collected from all Area Authorities via submitted Medicaid paid claims data. This data is submitted to the Division to staff in Management Services (Adam Holtzman). Area Authorities are currently submitting data on a routine basis. There will be no changes in the frequency of submissions. Data should be forwarded to the Division as it is obtained by Area	• Publish monitoring findings in periodic reports on performance. • Corrective Action for Area Programs that do not maintain previous year's penetration rate (within 1%) or do not meet or exceed benchmark of state average (within 1%).

REQUIREMENT	INTENT and AUTHORITY	MEASUREMENT	MONITORING and RESPONSIBLE PARTY	CONSEQUENCES FOR NON - PERFORMANCE
	This is a currently a high priority for the Division of MH/DD/SAS and DSS, as communicated via the joint memo to Area Directors and as supported in Memoranda of Agreement between Area Programs and local DSS.	data. And **B** = Number of children in DSS custody in Area Program catchment area. This will be obtained from Medicaid eligibility data. Penetration rates will be provided to Area Authorities on a quarterly basis through the performance contract report card; however, penetration rates will be evaluated on an annual basis.	Program. Analysis of data will be disseminated to Area Authorities, the Child and Family Services Section, the State Collaborative, and the Local Community Collaboratives.	
Service Delivery1: Offer an appointment to see individuals ***who choose*** the Area Program for follow-up care within five (5) working days after notification to the Area Program of discharge from state hospitals or ADATC's. If the client does not attend the appointment (i.e., no show), the Area Program will document that reasonable professional efforts were made to see, or reschedule, the client. • Adult Mental Health; and • Substance Abuse Services.	The intent of this requirement is for Area Authorities to provide follow-up services and treatment to clients who are discharged from State hospitals and ADATCs as quickly as possible.	The measure is the number of working days within which clients who are discharged from State hospitals and ADATCs and ***choose*** to be seen by Area Program staff. Benchmark will be that 90% of the clients for whom records are reviewed will be seen by Area Program staff within 5 working days of discharge, or will meet criteria that all reasonable professional effort was made to see, or reschedule, any "no show" clients. Reasonable effort is defined as documentation of at least one of the following within one week of the initial missed appointment: (1) a home visit or (2) a rescheduled	The auditors will visit each State Psychiatric Hospital to gather preliminary information that will clarify the efforts of both the area program and hospital staff in regards to admission and discharge duties and to develop a list of actual clients from each area program for whom the area program is responsible. Monitoring will be done through annual on-site reviews. Record reviews of a sample of 10 adults with psychiatric diagnoses discharged from State hospitals, for whom the discharge plan indicated the area program would be responsible for community treatment;	• Results will be included in the year end performance agreement report. • Corrective action plans are to be submitted for performance below the 90% benchmark. The plan must contain the timeframe and the steps that will be taken to implement improved performance.

REQUIREMENT	INTENT and AUTHORITY	MEASUREMENT	MONITORING and RESPONSIBLE PARTY	CONSEQUENCES FOR NON - PERFORMANCE
		office appointment that the client keeps or (3) a phone conversation with the client about the services being offered. Additionally, the institutional records will be reviewed to verify that the Area Program was notified of the discharge, the date and the clients choice of locations to be seen.	or, in the case of Substance Abuse, a sample of 10 substance abuse patients with abuse or dependence diagnoses, discharged from ADATCs, are to be included in Medicaid or other scheduled record reviews. Reviews of the sampled records will be included in on-site record reviews done by the Division staff who are responsible for this function. The results regarding adults discharged from State Psychiatric hospitals and ADATCs are to be reported to the Adult MH Section and the Substance Abuse Section, respectively.	